

# State Medical Board of Ohio

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Executive Director

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November 10, 2010

Edward Wai Wong, M.D.  
Flat K, 34<sup>th</sup> Floor  
Block 7  
Harbour Place, Hunghom  
Hong Kong, China

RE: Case No. 10-CRF-009

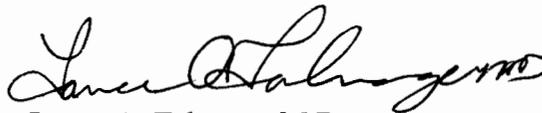
Dear Doctor Wong:

Please find enclosed certified copies of the Entry of Order; the Report and Recommendation of Patricia A. Davidson, Esq., Hearing Examiner, State Medical Board of Ohio; and an excerpt of draft Minutes of the State Medical Board, meeting in regular session on November 10, 2010, including motions approving and confirming the Report and Recommendation as the Findings and Order of the State Medical Board of Ohio.

Section 119.12, Ohio Revised Code, may authorize an appeal from this Order. Such an appeal must be taken to the Franklin County Court of Common Pleas.

Such an appeal must be commenced by the filing of a Notice of Appeal with the State Medical Board and the Franklin County Court of Common Pleas. The Notice of Appeal must set forth the Order appealed from and state that the State Medical Board's Order is not supported by reliable, probative, and substantive evidence and is not in accordance with law. The Notice of Appeal may, but is not required to, set forth the specific grounds of the appeal. Any such appeal must be filed within fifteen (15) days after the mailing of this notice and in accordance with the requirements of Section 119.12, Ohio Revised Code.

THE STATE MEDICAL BOARD OF OHIO



Lance A. Talmage, M.D.  
Secretary

LAT:jam  
Enclosures

REGISTERED MAIL NO. RR 323 471 071 US  
RETURN RECEIPT REQUESTED

Cc: Eric J. Plinke, Esq.  
CERTIFIED MAIL NO. 91 7108 2133 3934 3487 5645  
RETURN RECEIPT REQUESTED

*Mailed 11-12-10*

CERTIFICATION

I hereby certify that the attached copy of the Entry of Order of the State Medical Board of Ohio; Report and Recommendation of Patricia A. Davidson, State Medical Board Attorney Hearing Examiner; and excerpt of draft Minutes of the State Medical Board, meeting in regular session on November 10, 2010, including motions approving and confirming the Findings of Fact, Conclusions and Proposed Order of the Hearing Examiner as the Findings and Order of the State Medical Board of Ohio; constitute a true and complete copy of the Findings and Order of the State Medical Board in the matter of Edward Wai Wong, M.D., Case No. 10-CRF-009, as it appears in the Journal of the State Medical Board of Ohio.

This certification is made by authority of the State Medical Board of Ohio and in its behalf.



Lance A. Talmage, M.D.  
Secretary

(SEAL)

November 10, 2010  
Date

BEFORE THE STATE MEDICAL BOARD OF OHIO

IN THE MATTER OF

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CASE NO. 10-CRF-009

EDWARD WAI WONG, M.D.

\*

ENTRY OF ORDER

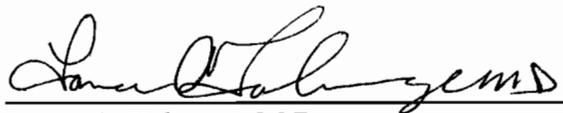
This matter came on for consideration before the State Medical Board of Ohio on November 10, 2010.

Upon the Report and Recommendation of Patricia A. Davidson State Medical Board Attorney Hearing Examiner, designated in this Matter pursuant to R.C. 4731.23, a true copy of which Report and Recommendation is attached hereto and incorporated herein, and upon the approval and confirmation by vote of the Board on the above date, the following Order is hereby entered on the Journal of the State Medical Board of Ohio for the above date.

It is hereby ORDERED that no further action be taken in the matter of Edward Wai Wong, M.D., in Case No. 10-CRF-009.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.

(SEAL)



Lance A. Talmage, M.D.  
Secretary

November 10, 2010

Date

**BEFORE THE STATE MEDICAL BOARD OF OHIO****In the Matter of**

\*

**Case No. 10-CRF-009****Edward Wai Wong, M.D.,**

\*

**Hearing Examiner Davidson****Respondent.**

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**REPORT AND RECOMMENDATION**Basis for Hearing

In a notice of opportunity for hearing dated January 13, 2010, the State Medical Board of Ohio notified Edward Wai Wong, M.D., that it intended to determine whether to take disciplinary action against his certificate to practice allopathic medicine and surgery in Ohio, based on actions taken by the Colorado Board of Medical Examiners [Colorado Board] and the Medical Board of California [California Board]. The Board further alleged that the actions taken by the Colorado Board and the California Board constituted an "action" by those boards under Ohio Revised Code Section [R.C.] 4731.22(B)(22).

The Board received Dr. Wong's request for hearing on January 21, 2010. (St. Ex. 1)

Appearances

Richard Cordray, Attorney General, and Karen A Unver, Assistant Attorney General, on behalf of the State. Eric J. Plinke, Esq., on behalf of Dr. Wong.

Hearing Date: August 26, 2010

**SUMMARY OF EVIDENCE**

All exhibits and the transcript, even if not specifically mentioned, were thoroughly reviewed and considered by the Hearing Examiner prior to preparing this Report and Recommendation.

**Background**

1. Edward Wai Wong, M.D., graduated from the University of Texas at Austin in 1991 and received his medical degree in 1995 from McGill University in Montreal, Canada. According to his curriculum vitae, he then completed the following postgraduate medical training: one year of internship in general surgery at the University of California at Los Angeles, which he completed in 1996; one year of residency in general surgery at Kern Medical Center in Bakersfield, California, completed in 1997; and a four-year residency in diagnostic radiology at the University of California at Irvine completed in 2001. (Resp. Ex. B; State of Ohio eLicense Center at <<https://license.ohio.gov/lookup/default.asp?division=78>>, accessed August 26, 2010.)

2. Dr. Wong stated that he then completed a one-year fellowship in emergency radiology at Massachusetts General Hospital in Boston in 2002. He also received a master's degree in public health from the Harvard School of Public Health in 2003. Dr. Wong further stated that, during the time he was working on his master's degree at Harvard, he also served as an instructor in radiology at the Harvard Medical School. (Resp. Ex. B)
3. Dr. Wong further stated that in 2002 he became board-certified by the American Board of Radiology. In 2003, the Board granted him a license to practice allopathic medicine and surgery in Ohio, under certificate number 35.083107. (Resp. Ex. B; Ohio eLicense Center, *supra*)
4. Dr. Wong resides in Hong Kong, China. Since 2003, he has worked as a teleradiologist employed by Virtual Radiologic Professionals, LLC, in Eden Prairie, Minnesota. (Resp. Ex. B; Ohio eLicense Center, *supra*)

#### **The Letter of Admonition from the Colorado Board**

5. The Colorado Board, in Case Number 2009-0237-B, issued a Letter of Admonition to Dr. Wong dated April 16, 2009, stating as follows:

Inquiry Panel B of the Colorado Board of Medical Examiners ("Panel") has concluded its inquiry regarding your role in the care and treatment of patient J.D. It was the Panel's decision not to commence with formal proceedings against your license to practice medicine. However, the Panel did vote to administer disciplinary action to you in the form of this letter of admonition.

As you may recall, on January 10, 2005, patient J.D. was diagnosed with bacteremia. On February 25, 2005, patient J.D. presented to the emergency department with a two-day history of headache. A CT was performed and interpreted by the on-site radiologist, who noted a lesion on the left side of the brain that was suspicious for malignancy, with stroke less likely. A contrast enhanced CT or MRI was recommended. J.D. was discharged with pain medication and follow up with an oncologist.

The following day J.D. returned to the emergency department with nausea, vomiting, and continuing headache. A contrast CT was performed that you interpreted electronically, noting a 1.1 cm. ring-enhanced mass in the left parietal lobe, with surrounding attenuation. Although you noted that a CT scan was taken the day before, you did not request the prior exam for comparison. The final interpretation by an on-site radiologist concurred with your findings and interpreted them as "worrisome for metastatic disease." J.D. was thereafter discharged. Days later the patient collapsed and was brought back to the emergency department. She was eventually diagnosed with meningitis and brain abscess.

After a review of all the information in the matter, the Panel found that your care and treatment of patient J.D. fell below the generally accepted standards of practice for a radiologist, constituting a violation of section 12-36-117 of the Colorado Revised Statutes. Specifically, you failed to consider a diagnosis of abscess, and you failed to request copies of the prior exam taken the previous day in order to compare the two studies.

By this letter, the Panel hereby admonishes you and cautions you that complaints disclosing any repetition of such practice may lead to the commencement of formal disciplinary proceedings against your license to practice medicine, wherein this letter of admonition may be entered into evidence as aggravation.

You are advised that it is your right to have this case reviewed in an administrative proceeding. To do so, you must submit a written request \* \* \*. In your request, you must clearly ask that formal disciplinary proceedings be initiated against you to adjudicate the propriety of the conduct upon which this letter of admonition is based. If such request is timely made, this letter of admonition will be deemed vacated and the matter will be processed by means of a formal complaint and hearing. \* \* \*

(St. Ex. 2)

### **The Public Letter of Reprimand from the California Board**

6. On July 21, 2009, the California Board issued a reprimand to Dr. Wong, based on the same incident on which the admonition by the Colorado Board was based:

Re: Physician's and Surgeon's Certificate Number: A 62280  
Case Number: 16-2009-199296

#### Public Letter of Reprimand

On May 15, 2009, the Colorado State Board of Medical Examiners issued a Letter of Admonishment based upon findings that your case and treatment of a patient fell below the general accepted standard of practice for a radiologist in that you failed to consider a diagnosis of abscess and failed to request copies of the prior exam in order to compare the two studies. These actions are in violation of California Business and Profession Code sections 141(a), 2234 and 2305, disciplinary action taken by others and unprofessional conduct.

Pursuant to the provisions of California Business and Professions Code section 2233, you are hereby issued this Public Letter of Reprimand.

(St. Ex. 3)

7. A number of other medical licensing boards have received information regarding the malpractice settlement addressed in the Colorado and California letters and/or have received information regarding the actions taken by the Colorado and California Boards, with the following results:
- Arizona Medical Board, Case #MD-08-0898A (October 7, 2008): “The Arizona Medical Board has thoroughly investigated this case and found no violation of the Medical Practice Act. Therefore, this case has been dismissed.” (Resp. Ex. C at 1)
  - Connecticut Department of Public Health, Practitioner Licensing and Investigations Unit (June 19, 2009, regarding the malpractice settlement): “Please be advised that the Department has completed its review and has decided not to pursue a formal investigation of this specific malpractice settlement at this time. Therefore, this review has been closed.” (Resp. Ex. C at 3)
  - Connecticut Department of Public Health, Practitioner Licensing and Investigations Unit (August 31, 2009, regarding the “action” by the Colorado and California Boards): “The Practitioner Licensing and Investigation Section has completed its review of these issues and has elected not to pursue a formal investigation into this matter.” (Resp. Ex. C at 4)
  - Connecticut Department of Public Health, Practitioner Licensing and Investigations Unit, Petition No. 2010-241 (March 22, 2010, regarding the Letter of Admonition from the Colorado Board and the Public Reprimand from the California Board): “Please be advised that the Department has completed its review and has decided not to pursue a formal investigation of this settlement at this time.” (Resp. Ex. C at 5)
  - Indiana Medical Licensing Board, License # 01058260A (July 22, 2008): “We have received the documents pertaining to the settlement of the malpractice claim. Please note that this information should be reported on your license renewal when you renew in 2009.” (Resp. Ex. C at 7)
  - Massachusetts Board of Registration of Medicine (November 7, 2008): “Please be advised that I have administratively closed this matter. No further information needs to be provided at this time.” (Resp. Ex. C at 9)
  - Minnesota Board of Medical Practice, File No. WRM07080037 (October 23, 2008): “As you will recall from previous contact, the Board of Medical Practice has conducted a review of a report involving your practice of medicine. After a thorough review of both the Medical Practice Act and the facts of the situation, including those that you have provided, the Board has decided to dismiss the matter.” (Resp. Ex. C at 11)
  - Minnesota Board of Medical Practice, Board File No. WRM07080037 (April 22, 2010): “As you will recall from previous contact, the Board of Medical Practice has

conducted a review of a report involving your practice of medicine. After a thorough review of both the Medical Practice Act and the facts of the situation, including those that you have provided, the Board has decided to close its investigation at this time. However, this report will remain on file and the investigation may be re-opened in the future if the Board receives similar reports regarding your practice of medicine.” (Resp. Ex. C at 13)

- New Hampshire Board of Medicine (May 5, 2010): “The Board has completed its investigation regarding [name omitted]. Based on the information available in this case, the Board has determined that no further action is warranted. \* \* \* [T]he Board has the option of resolving each investigation by seeking public discipline, issuing a confidential letter of concern to the physician or physician assistant, or taking no further action.” (Resp. Ex. C at 15)

The New Hampshire Board noted that Dr. Wong had informed it that “no disciplinary action but confidential advisory letters/letters of warning have been issued by Medical Boards in the states of Tennessee, Iowa and Virginia.” (Resp. Ex. C at 15)

- Pennsylvania Department of State, File No. 09-49-6277 (August 24, 2009): “The Department of State Office of Chief Counsel has completed its inquiry \* \* \*. After prosecutorial review, this office has decided to defer formal prosecution against you. \* \* \* Considering your record with the Board as well as the *de minimus* nature of the Colorado Board’s disciplinary action, this office has determined that formal action against your license is not warranted at this time. However, please be advised that future violations of this nature will result in the filing of formal charges against your license \* \* \*. The Prosecution Division reserves the right to reopen this case for any reason, such as if we receive additional information.” (Resp. Ex. C at 17)
- State of Washington Medical Quality Assurance Commission, Case No. 2009-136495MD (July 17, 2009): “The Medical Quality Assurance Commission has completed its investigation regarding allegations of unprofessional conduct. \* \* \* After careful consideration of the records and information obtained during its investigation, it was determined that disciplinary action is not necessary.” (Resp. Ex. C at 19)
- Wisconsin Department of Regulation & Licensing, Matter 08 MED 230 (October 21, 2009): “The Medical Examining Board received information complaining of your practice. This information was reviewed for the purpose of determining whether disciplinary proceedings should be brought against you. \* \* \* Upon completion of this investigation, representatives of the Division of Enforcement presented the relevant facts to the Board. After considering the matter, the Board closed the case for No Violation, finding there is sufficient evidence to show that no violation of statutes or rules occurred.” (Resp. Ex. C at 19)

### **Dr. Wong's Statement to the Board**

8. In a written statement to the Board, Dr. Wong explained that he resides in Hong Kong and apologized for not being able to attend the hearing in person. He provided a lengthy explanation of the incident underlying the action taken by the Colorado Board, which then resulted in action being taken by the California Board. His written explanation is interspersed with copies of numerous documents, primarily medical records of the patient whose treatment was at issue, and also includes his arguments to the Board, as follows:

Your letter of January 13, 2010, states that you are reviewing the issuance of a letter of admonition by a Panel of the Colorado Board of Medical Examiners and the Medical Board of California's issuance of a letter of reprimand based on the Colorado Panel's admonishment. As stated in the Colorado Panel's admonishment, that letter was issued based upon the Panel's review of my care of a patient, who they identified as "J.D." That case was also a malpractice case that was settled. The Panel of the Colorado Board stated in its letter that it had "decided not to commence formal disciplinary proceedings against (my) license to practice medicine." It further advised me that I could request an administrative proceeding which would initiate the formal disciplinary process and vacate the admonishment letter. I chose not to initiate the formal disciplinary process.

The Panel of the Colorado Board concluded that my care fell below "generally accepted standards of practice for a radiologist," and specifically, that 1) I failed to "consider a diagnosis of abscess;" and 2) that I failed to "request copies of the prior exam taken the previous day to compare the two studies." I disagree and the following is my response to these issues and a summary of the medical care I provided to patient J.D.<sup>1</sup> My hope is that this information will show why further disciplinary action is not warranted.

#### **Narrative**

My only involvement in the medical care of patient J.D. was my interpretation of her CT scan of the brain on Feb 26, 2005, shortly after the images were obtained at Charles Cole Hospital, Coudersport, PA, and then electronically transmitted to my work computer. As is typical of rural community hospitals, no radiologist was on-site to interpret the study during overnight hours. In such circumstances, the hospital utilizes teleradiology, and transmits the images to a radiology service, which in this case was Virtual Radiologic Professionals of Minneapolis, Minnesota.

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<sup>1</sup>If Dr. Wong had requested a hearing in the Colorado matter, he could have explained his disagreement at that time and presented evidence and arguments in his favor. It is important to note that the quoted statements from Dr. Wong were not made under oath and were not subject to cross-examination by the Assistant Attorney General at the hearing, or subject to observation by the Hearing Examiner.

I am one of Virtual Radiologic's approximately one hundred and forty U.S. trained, board certified radiologists. Standardized hardware and software are provided by Virtual Radiologic to each radiologist. Of note, Virtual Radiologic provides service to over 1200 facilities, accounting for over 21 % of all US hospitals. At anytime at night, there are over 50 radiologists online, with expertise covering each subspecialty area, allowing for real-time consultations.

I generated a preliminary report based on the images and non-imaging information provided to me. The medical records from Charles Cole Hospital include a copy of the report that I generated, which also contains the non-imaging information provided to me. The non-imaging information given to me at the time of my interpretation included the patient's name, medical record number, age (30 year old), gender (female), date of the examination (2-26-2005), study type (CT Brain with contrast), name of referring physician (Dr. Shultz), total number of images (26) and clinical history ("HA; attention, l.parietal/temporal mass on noncontrast done 2/25/05"). Regarding the Colorado's Panel's criticisms, information was sent to me that there was no prior study available for comparison. As a result, I stated that in my report.

At the time of my interpretation, all the non-imaging information was viewable in the software interface. Because Virtual Radiologic and its radiologists did not have and could not have access to the medical information systems or PACs of our client hospitals, we rely on the hospitals (namely the technologists) to affirmatively send information to us. In particular, images have to be affirmatively sent by the hospital technologist to us. Realizing this is such a critical step, the responsibility has been clearly stated in the contractual agreements which was th[e] case with Charles Cole Hospital.

To minimize human error, before sending the case to our server, the technologist had to electronically enter whether or not prior images are available, among other information.

[Omitted: an image of the screen that the hospital technician sees when using the computer system to send images to Virtual Radiologic. According to the caption provided by Dr. Wong, the interface includes a specific field for the hospital technician to tell the radiologist whether additional information, such as comparison images or a comparison report, is available. *See* Resp. Ex. A at 2.]

Regarding the presence or absence of the study, I have to rely on the information provided on the software interface. In the case of patient J.D., it was indicated in more than one location that there was no prior study available for comparison. As a result, I stated that in my report.

On 2/26/05, in reviewing patient J.D.'s case, I identified the clinical information provided by the referring physician, that indicated a mass was diagnosed on an unenhanced CT on the preceding day (2/25). Given i) the close temporal relationship between the two studies, ii) the fact that an enhanced CT was ordered after a mass was diagnosed by an unenhanced CT, and iii) that the study was done in the early morning hours, I understood that the current study was a continuation of the unenhanced portion of the study done as a part of the pre-operative work up. Seeing orders of pre-op CT just hours before surgery is very common in my practice of emergency radiology. This situation is so standard that most referring physicians do not even want to be called by phone on the findings. In the past, I did not call the referring physicians by phone on these findings. Although not standard practice, after this case, I have called more often on similar preoperative case. Sometimes, the referring physicians would politely thank me for the information, and some would decline such phone calls. All 26 images for the patient were reviewed and all of images are part of the medical record. Upon reviewing all images, I sent out the report, which would have been received by the referring physician, in the form of a fax, as follows:

[Omitted: an image of the actual radiology report by Dr. Wong. (See Resp. Ex. A at 3) In lieu of that image, the Hearing Examiner provides the pertinent statements in the report immediately below:]

### **Preliminary Radiology Report**

Name: (redacted)                      Age: 30F                      Date: 2-26-2005

Study: CT BRAIN/HEAD W CONTRAST

Images: 26:                      Add'l Studies:

Clinical History: HA; attention, l.parietal/temporal mass on non-contrast done 2/25/06

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ENHANCED CT OF HEAD – 26 images

Clinical information: HA, attention, l.parietal/temporal mass on non-contrast done 2/25/06

No prior study is available for comparison.

#### **IMPRESSION:**

A 1.1 cm ring enhancement in a mass in the region of the left low parietal lobe, with anterior hypodense area (25Hus) ? edema. The mass appears to extend inferiorly to the temporal lobe. MR may further characterize it, if clinically indicated.

No hydrocephalus or midline shift.

Lucencies in the posterior skull, loc 107. ? post-surgical vs. normal variants.

\* \* \*

Dictated and Authenticated by: Edward Wong, M.D.  
2-26-2005 5:37 a.m. Central Time

My report was transmitted to Charles Cole Memorial Hospital Emergency Department in the form of a fax at 6:37 a.m. Eastern Time and was reviewed by Dr. Schultz, the referring physician.

As is typical for overnight teleradiology reading, the report I issued was a **preliminary report**. A preliminary report is also known as a "wet reading." It is meant to convey the most critical information relevant to the immediate care of the patient. This is in contrast to a **final report**, which is a report that typically conveys more information, possibly after incorporation of additional clinical information and additional imaging information. As such, each study from which a preliminary report was issued will be reevaluated again, by another radiologist, typically one that covers the hospital during regular hours. [Emphasis in original.]

I believe that my preliminary report in this case was consistent with the American College Of Radiology Practice Guideline for Communication of Diagnostic Imaging Findings, which provides that: "A preliminary report precedes the final report and contains limited information. It may be time sensitive, and it should not be expected to contain all the reportable findings. A preliminary report may not have the benefit of prior imaging studies and/or reports and may be based upon incomplete information due to evolving clinical circumstances. Therefore, its accuracy may be compromised. Nevertheless, clinical decision making may be based on this report due to the need for immediate patient management. The situations that may require preliminary reports may include, but are not limited to, the use of teleradiology interpretations provided to emergency and surgical departments and critical care units, or initial readings provided by trainees."

In the case of the CT of the brain done on 2/26/05 for patient J.D., for which I issued the preliminary report, Dr. Frank D'Amelio issued the final report, as follows:

[Omitted: image of the actual report. In lieu of that image, the Hearing Examiner has provided below the pertinent statements in the report.]

CLINICAL HISTORY: HEADACHE

\* \* \*

CLINICAL HISTORY: ATTN LT PARIETAL/TEMPORAL MASS ON NONCONTRAST CT

DATE: 02/26/05

CT OF THE HEAD WITH CONTRAST

This is follow-up of a study that was done on 02/25/05.

In the region of the left temporal parietal area, is a 1 centimeter enhancing lesion with an area of surrounding edema which involves both the left temporal lobe and the left parietal lobe. There does not appear to be any midline shift. However, there appears to be some compression of the left lateral ventricle, especially in the occipital horn region. I saw no other evidence for abnormality. In the differential one would have to be concerned with a malignancy, most likely metastatic but primary cannot be excluded.

What is visualized of the brain stem, cerebellum, remainder of the supratentorial gray and white matter, extraaxial region, and calvarium are otherwise unremarkable.

**IMPRESSION:** a 1 centimeter lesion involving the left temporal parietal area with a large amount of edema worrisome for metastatic focus. A primary malignancy is also of concern. No other lesions were identified. There is a fair amount of edema associated with this lesion with some compression of the left lateral ventricle. This is also causing some expansion of the left temporal horn of the ventricular system. No other lesions identified.

Typically, the radiologist who generates the final report will have in his or her possession at the time of reporting the images and a copy of the preliminary report. If he or she disagrees with the preliminary report, hence there is a discrepancy, he or she will typically notify the referring physician of the discrepancy. In addition, he or she will indicate such a discrepancy in the final report and notify Virtual Radiologic (which in turn notifies the radiologist who issued the preliminary report) of the discrepancy, which can be done as simply as circling the appropriate boxes in any page of the preliminary report and send[ing] it to the fax number provided. I do not have any personal recollection about this case. However, Dr. D'Amelio noted no discrepancy in his Final Report.

Patient J.D. had initially presented to Charles Cole Hospital Emergency Department shortly before Dr. Schultz started his shift at 7 p.m. on 2/25/08 with a two-day history of headache. An unenhanced CT was performed. Dr. Schultz then discussed the case over the phone with Dr. Pyatt, a member of the group of the radiologists at the hospital. Dr. Pyatt then issued a preliminary report. Days later, Dr. Pyatt issued a final report. They are attached here for your convenience.

[Omitted: image of a handwritten report regarding a wet reading of the noncontrast CT, and image of a formal report regarding the noncontrast CT. The radiologist who made the formal report noted, among other things, the following: that the area is suspicious for a malignancy; that a less likely consideration in a patient of this age is a cerebrovascular accident; that no "acute process" was identified; that further evaluation with cranial MRI with gadolinium "would be the most helpful

examination at this point”; that “a less optimal examination” would be a contrast head CT but that an MRI “would be much better”; and that the radiologist appreciated the clinical information provided to him personally by the referring physician. *See Resp. Ex. A at 5.*]

MRI was not available nights or weekend[s] at Charles Cole Memorial Hospital, but was to be available the following Monday morning. Dr. Schultz discussed the finding with the internist on call who happened to be an oncologist, Dr. DeLo, who agreed to see the patient after an MRI could be completed. The patient was given Vicodin for pain in the ER and additional Vicodin to take home. She was discharged home with discharge instructions. Upon discharge, the headache was rated at 6/10.

Patient J.D.’s condition worsened and she called the Emergency Department on 2/26/05 at 12:55am. She returned to the Emergency Department at 5 a.m. for continued headache, now accompanied by new nausea and vomiting, photophobia and neck pain. Her past medical history is significant for blood infection and catheter infection (Jan 2005) after precedent dental and stomach surgery. She was again evaluated by Dr. Schultz. The initial vital signs were normal with no fever. However, another temperature was taken at 6:50 a.m., which showed low grade fever of 100.1. She had a high white blood count of 13,900 cells/ml (with 88% neutrophils). Intravenous steroid was ordered at 6:30 am and administered. My faxed CT report was received in the ED at 6:37 am. Dr. Schultz consulted with the on call internist Dr. DeLo by phone again. A discharge order was made. A discharge summary was given to the patient at 6:52 am. Patient J.D. stayed in the ED until 10 am when she would get a ride home from her friend.

Emergency Physician Record:

[Omitted: image of handwritten notes on a hospital form, showing the symptoms reported, and the lab results for the blood count, chemistries, and urinalysis. *See Resp. Ex. A at 6.*]

Emergency Physician Order:

[Omitted: image of handwritten notes on a form, showing the administration in the ER of the following medications: 10 mg Reglan, 30 mg Toradol, 3 mg Morphine, 25 mg Benadryl (with a note regarding a rash); 125 mg Phenergan, 10 mg Decadron (dexamethasone), and 2 mg Morphine. *See Resp. Ex. A at 6.*]

Emergency Department Discharge Summary for patient:

[Omitted: image of discharge summary, including follow-up information as follows: “On 02/26/2005 this patient was treated in the

Emergency Department \* \* \* for NONSPECIFIC HEADACHE, VOMITING. The patient was asked to follow up Tuesday – Call.” In addition, the discharge summary notes that the patient was given prescriptions for Phenergan, Celebrex, and Prednisone. *See Resp. Ex. A at 7.]*

On 2/28/05, patient J.D. was brought to the ED by ambulance after being found on her bathroom floor at 6:30 am by her parents. She had a GCS of 7. Unenhanced CT reported by Dr. D’Amelio revealed progression of edematous changes involving left temporal parietal region compared to CT of 2/26/05. The following are the preliminary and final reports of the CTs of 2/28/05.

[Omitted: image of handwritten wet reading of CT study on 2/28/05, and image of a formal report regarding that study, noting among other things that there were extensive edematous changes that had progressed since the previous study, effacement of the left lateral ventricular system, dilation of both temporal horns, effacement of the 4th ventricle and brainstem, and that it was difficult to say with certainty whether there was a focal bleed due to limitations caused by motion. *See Resp. Ex. A at 8.)*

Patient J.D. was transferred to Erie County Medical Center where she was subsequently diagnosed and treated for a brain abscess. She recovered and at one point was discharged from all therapies and living independently. She could drive and she attended a community college with a B average. However, subsequently, she developed ventriculoperitoneal malfunction. Its revision was complicated and her functional status deteriorated to the point when she could no longer be living independently at the time of the malpractice settlement.

#### **Summary and my views on the standard of care issues.**

Information provided to me indicated that the prior CT of 2/25/05 was not available for comparison. Had the referring physician, Dr. Schultz, requested a comparison of the two studies and had the images of the CT of 2/25/05 been sent to me, I would have concluded (then and now) that there was not significant progression of the imaging pathology. The fact that an old study was not sent to me and that the referring physician did not ask for a comparison indicated that my comparison with a prior study upon issuing the preliminary report could not be made or was not needed. In this case, as I do on a regular basis, I indicated the presence or absence of a prior study in my assessment of the images I was provided. In addition, the history conveyed to me indicated a mass lesion was seen on an unenhanced study. I reasonably understood that this referral was a continuation of the unenhanced portion of the study for possible surgical planning and I was being asked to clarify the presence and size of the known mass to be better defined by the contrast. This is a reasonable approach under the circumstances of this preliminary report which is to

be issued overnight and which will be subject to a separate and final review and report by the local radiologist.

**Obtaining prior exam images:** As for the standard of care position taken by the Colorado Panel that my care was below standard because I failed to "request copies of the prior exam taken the previous day to compare the two studies," I do not agree. In fact, I believe that the Panel's position is contrary to the position statement of the American College of Radiology ("ACR") on the subject of preliminary reports and review of prior images. As stated above, I was informed that the studies were not available so even if this were the standard, it would not be applicable in this circumstance where the images are said to be unavailable. Moreover, I do not agree that in the context of a preliminary report that this is the standard of care. In obtaining prior studies when providing a preliminary report, it can be an advantage, but it is not the standard of care. Providing preliminary reports is exclusively what I do for Virtual Radiologic and it accounts for the majority of work of my radiologist colleagues at Virtual Radiologic. My fellowship training was in Emergency Radiology. After I completed fellowship training at Harvard, I remained on staff at Massachusetts General Hospital and practiced as an attending in emergency radiology (with duties including teaching residents and fellows), prior to joining Virtual Radiologic over seven years ago. I believe that I am familiar with the standard of care in this area and that my preliminary report in this case was consistent with the ACR's position.

**Consideration of a diagnosis of abscess:** As for the standard of care position taken by the Colorado Panel that my care was below standard because I failed to "consider a diagnosis of abscess," I do not agree. As stated above, I was provided limited information regarding the patient. It is clear that the standard of care does not require a radiographic differential diagnosis for every case. For example, the imaging report for an uncomplicated fracture calls for the description of the fracture but a differential diagnosis would neither be necessary nor appropriate. I believe my radiographic description of the lesion was within the standard of care.

In this case of a brain mass for a 30 year old with no imaging evidence of adjacent surgery or trauma, and a lack of clinical information suggestive of infection at the time of my preliminary report, the diagnosis of a brain neoplasm is by far a more common diagnosis (given its prevalence of greater than 99%) than an abscess, which is very rare, or other entities. This opinion was shared independently by Dr. Pyatt and Dr. D'Amelio, as demonstrated by both in their CT reports.

**Difference between preliminary reporting and final reporting:**

As mentioned above, the preliminary reading and final reporting are different, in their nature, purpose and emphasis. Both are important and both need to be accurate. One very unique feature reasonably expected for preliminary reading is the timeliness in

reporting the most relevant finding(s). These are best illustrated by reviewing the preliminary report and final report side by side, as can be done for the CT of 2/25/05 and CT of 2/28/05 provided above.

### **Issuance of Letter of Admonition by the Colorado State Board of Medical Examiners**

Due to the costs and uncertainty of litigating this matter that encompassed three admissions to the Emergency Department and six individual physicians, their employers and the hospital, my insurance carrier, at its sole discretion, entered into a global settlement. There was no admission of liability by me. Following the settlement and payment of this case, I self-reported both to every medical board where I was licensed to practice medicine, including Ohio. As a result, several states opened routine reviews into the case, and requested additional information. One of these states was Colorado.

On July 24, 2008 the Colorado [Panel] sent a request to me for additional documents, patient records and an explanation regarding this case. I provided all the requested documentation and, following their review, the Panel sent me the letter of admonition dated April 16, 2009. I was given the option of filing a request to have the Letter of Admonition issued by the Colorado Panel reviewed by the disciplinary process, but instead chose not to initiate the disciplinary process. The Letter of Admonition was reported by the Colorado State Board of Medical Examiners to the Federation of State Medical Boards on May 2, 2009, and to the National Practitioner Data Bank on May 15, 2009. This action was self-reported by me to every state where I am licensed to practice medicine.

As a result of the Letter of Admonition issued by the Colorado board, on June 5, 2009 the Medical Board of California offered me the option of accepting a Public Letter of Reprimand in lieu of filing a formal Accusation and opportunity for hearing. This was issued as a reciprocal action in response to the initial action taken by Colorado. I chose to accept the Public Letter of Reprimand, and it was enacted by their board on July 21, 2009. The Public Letter of Reprimand was reported by the California Medical Board to the FSMB on August 7, 2009 and to the NPDB/HIPDB on August 20, 2009.

Because of my position as a teleradiologist, I am licensed in multiple jurisdictions and have thus been required to respond to multiple inquiries regarding this matter. Several State Boards have concluded that no disciplinary action is indicated, including the State where this lawsuit arose, Pennsylvania. I have also received letters indicating that no disciplinary action will be taken by the Medical Boards in the states of Arizona, Connecticut, Indiana, Massachusetts, Minnesota, New Hampshire, North Carolina, Washington and Wisconsin. Further, no disciplinary

action but confidential advisory letters/letters of warning have been issued by Medical Boards in the states of Tennessee, Iowa, and Virginia.

I thank you for your time and effort in reviewing this matter. I have attached a copy of my CV and letters from the various Boards who have reviewed this matter. I respectfully request that no discipline be imposed against me in this matter.

(Resp. Ex. A)

### **FINDINGS OF FACT**

On April 16, 2009, the Colorado Board of Medical Examiners issued a Letter of Admonition to Edward Wai Wong, M.D. On July 21, 2009, the Medical Board of California issued a Public Letter of Reprimand to Dr. Wong, based on the same incident underlying the Letter of Admonition from Colorado.

### **CONCLUSION OF LAW**

The admonition to Dr. Wong from the Colorado Board and the reprimand from the California Board, as set forth above in the Findings of Fact, individually and/or collectively constitute “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery \* \* \* in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand,” as that language is used in R.C. 4731.22(B)(22).

### **DISCUSSION OF PROPOSED ORDER**

Action was indeed taken by medical boards in Colorado and California, constituting censure or other reprimand. However, there is no need for this Board to administer another reprimand to Dr. Wong. He has undergone inquiries and investigations by numerous medical boards regarding the single incident at issue, and nothing further is needed to protect the public in Ohio. Among other things, an order of “no further action” would mean that this Board had grounds for citing the matter and pursuing an administration action, and assures that the public in Ohio will have ready access to the information regarding the actions taken by Colorado and California with regard to Dr. Wong.

**PROPOSED ORDER**

It is hereby ORDERED that no further action be taken in the matter of Edward Wai Wong, M.D., in Case No. 10-CRF-009.

This Order shall become effective immediately upon the mailing of the notification of approval by the Board.



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Patricia A. Davidson  
Hearing Examiner

# State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.  
Executive Director

(614) 466-3934  
med.ohio.gov

## EXCERPT FROM THE DRAFT MINUTES OF NOVEMBER 10, 2010

### REPORTS AND RECOMMENDATIONS AND PROPOSED FINDINGS AND PROPOSED ORDERS

Dr. Amato announced that the Board would now consider the Reports and Recommendations, and the Proposed Findings and Proposed Order appearing on its agenda.

Dr. Amato asked whether each member of the Board had received, read and considered the hearing records; the Findings of Fact, Conclusions of Law, Proposed Orders, and any objections filed in the matters of: Imam Michel Bastawros, M.D.; Darrell A. Hall, M.D.; Wesley Frank Hard, M.D.; Florence Beth Matyas, M.D.; Mehmet Akif Sungurlu, M.D.; and Edward Wai Wong, M.D. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Suppan	- aye
	Dr. Amato	- aye
	Mr. Albert	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Steinbergh	- aye
	Mr. Morris	- aye

Dr. Amato asked whether each member of the Board understands that the disciplinary guidelines do not limit any sanction to be imposed, and that the range of sanctions available in each matter runs from dismissal to permanent revocation. A roll call was taken:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Suppan	- aye
	Dr. Amato	- aye
	Mr. Albert	- aye
	Dr. Madia	- aye
	Dr. Talmage	- aye
	Dr. Steinbergh	- aye
	Mr. Morris	- aye

Dr. Amato noted that, in accordance with the provision in section 4731.22(F)(2), Ohio Revised Code, specifying that no member of the Board who supervises the investigation of a case shall participate in

further adjudication of the case, the Secretary and Supervising Member must abstain from further participation in the adjudication of these matters. In the matters before the Board today, Dr. Talmage served as Secretary and Mr. Albert served as Supervising Member. In addition, Dr. Mahajan served as Acting Secretary in the matter of Darrell A. Hall, M.D.; and Dr. Amato served as Acting Supervising Member in the matter of Wesley Frank Hard, M.D.; therefore, those Board members may not vote in those respective matters. Dr. Amato stated that all Board members may vote on the matter of Imam Michel Bastawros, M.D., as that case is not disciplinary in nature and only involves the respondent's qualifications for licensure.

Dr. Amato reminded all parties that no oral motions may be made during these proceedings.

The original Reports and Recommendations shall be maintained in the exhibits section of this Journal.

.....  
EDWARD WAI WONG, M.D.  
.....

**Dr. Steinbergh moved to approve and confirm Ms. Davidson's Findings of Fact, Conclusions of Law, and Proposed Order in the matter of Edward Wai Wong, M.D. Dr. Mahajan seconded the motion.**

.....  
A vote was taken on Dr. Steinbergh's motion to approve and confirm:

ROLL CALL:	Dr. Strafford	- aye
	Mr. Hairston	- aye
	Dr. Stephens	- aye
	Dr. Mahajan	- aye
	Dr. Suppan	- aye
	Dr. Amato	- aye
	Mr. Albert	- abstain
	Dr. Madia	- aye
	Dr. Talmage	- abstain
	Dr. Steinbergh	- aye
	Mr. Morris	- aye

The motion carried.

# State Medical Board of Ohio

30 E. Broad Street, 3rd Floor, Columbus, OH 43215-6127

Richard A. Whitehouse, Esq.  
Executive Director

(614) 466-3934  
med.ohio.gov

January 13, 2010

Case number: 10-CRF-009

Edward Wai Wong, M.D.  
Virtual Radiologic Professionals, LLC  
11995 Singletree Lane  
Suite 500  
Eden Prairie, MN 55344

Dear Doctor Wong:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

- (1) On or about April 16, 2009, the State of Colorado, State Board of Medical Examiners issued to you a Letter of Admonition [Colorado Letter]. Shortly thereafter, on or about July 21, 2009, the Medical Board of California issued to you a Public Letter of Reprimand [California Letter]. Copies of the Colorado Letter and California Letter are attached hereto and incorporated herein.

The Colorado Letter and California Letter, as alleged in paragraph (1) above, individually and/or collectively, constitute “[a]ny of the following actions taken by the agency responsible for regulating the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or the limited branches of medicine in another jurisdiction, for any reason other than the nonpayment of fees: the limitation, revocation, or suspension of an individual's license to practice; acceptance of an individual's license surrender; denial of a license; refusal to renew or reinstate a license; imposition of probation; or issuance of an order of censure or other reprimand,” as that clause is used in Section 4731.22(B)(22), Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing and must be received in the offices of the State Medical Board within thirty days of the time of mailing of this notice.

*Mailed 01-14-10*

Edward Wai Wong, M.D.

Page 2

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of mailing of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke, suspend, refuse to register or reinstate your certificate to practice medicine and surgery or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant a certificate to an applicant, revokes an individual's certificate to practice, refuses to register an applicant, or refuses to reinstate an individual's certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a certificate to practice and the board shall not accept an application for reinstatement of the certificate or for issuance of a new certificate."

Copies of the applicable sections are enclosed for your information.

Very truly yours,



Lance A. Talmage, M.D.  
Secretary

LAT/AMM/flb  
Enclosures

CERTIFIED MAIL #91 7108 2133 3936 3070 8594  
RETURN RECEIPT REQUESTED

cc: Eric J. Plinke  
Dinsmore & Shohl, LLP  
191 West Nationwide Blvd.  
Columbus, OH 43215-8120

CERTIFIED MAIL #91 7108 2133 3936 3070 8587  
RETURN RECEIPT REQUESTED

# STATE OF COLORADO

**STATE BOARD OF MEDICAL EXAMINERS**  
Cheryl Hara, Program Director

1560 Broadway, Suite 1300  
Denver, Colorado 80202-5146  
Phone (303) 894-7690  
Fax (303) 894-7692  
TTY: Dial 711 for Relay Colorado  
[www.dora.state.co.us/medical](http://www.dora.state.co.us/medical)

**Department of Regulatory Agencies**  
D. Rico Munn  
Executive Director

**Division of Registrations**  
Rosemary McCool  
Director



Bill Ritter, Jr.  
Governor

**VIA CERTIFIED MAIL**

April 16, 2009  
Case No. 2009-000237-B

**MEDICAL BOARD**

JUN 25 2009

Edward W. Wong, M.D.  
11995 Singletree Lane, Suite 500  
Eden Prairie, MN 55344

Dear Dr. Wong:

Inquiry Panel B of the Colorado Board of Medical Examiners ("Panel") has concluded its inquiry regarding your role in the care and treatment of patient J.D. It was the Panel's decision not to commence with formal proceedings against your license to practice medicine. However, the Panel did vote to administer disciplinary action to you in the form of this letter of admonition.

As you may recall, on January 10, 2005, patient J.D. was diagnosed with bacteremia. On February 25, 2005, patient J.D. presented to the emergency department with a two-day history of headache. A CT was performed and interpreted by the on-site radiologist, who noted a lesion on the left side of the brain that was suspicious for malignancy, with stroke less likely. A contrast enhanced CT or MRI was recommended. J.D. was discharged with pain medication and follow up with an oncologist.

The following day J.D. returned to the emergency department with nausea, vomiting, and continuing headache. A contrast CT was performed that you interpreted electronically, noting a 1.1 cm. ring-enhanced mass in the left parietal lobe, with surrounding attenuation. Although you noted that a CT scan was taken the day before, you did not request the prior exam for comparison. The final interpretation by an on-site radiologist concurred with your findings and interpreted them as "worrisome for metastatic disease." J.D. was thereafter discharged. Days later the patient collapsed and was brought back to the emergency department. She was eventually diagnosed with meningitis and brain abscess.

After a review of all the information in this matter, the Panel found that your care and treatment of patient J.D. fell below the generally accepted standards of practice for a radiologist, constituting a violation of section 12-36-117 of the Colorado Revised Statutes. Specifically, you failed to consider a diagnosis of abscess, and you failed to request copies of the prior exam taken the previous day in order to compare the two studies.

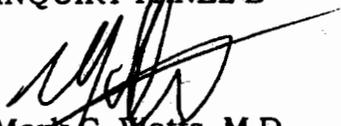
Letter to Edward W. Wong, M.D.  
Case No. 2009-000237-B  
April 16, 2009  
Page Two

By this letter, the Panel hereby admonishes you and cautions you that complaints disclosing any repetition of such practice may lead to the commencement of formal disciplinary proceedings against your license to practice medicine, wherein this letter of admonition may be entered into evidence as aggravation.

You are advised that it is your right to have this case reviewed in an administrative proceeding. To do so, you must submit a written request within twenty (20) days after receipt of this letter. In your request, you must clearly ask that formal disciplinary proceedings be initiated against you to adjudicate the propriety of the conduct upon which this letter of admonition is based. If such request is timely made, this letter of admonition will be deemed vacated and the matter will be processed by means of a formal complaint and hearing. This is in accordance with the provisions of the Medical Practice Act governing the discipline of licensed physicians.

Sincerely,

FOR THE BOARD OF MEDICAL EXAMINERS  
INQUIRY PANEL B



Mark C. Watts, M.D.  
Chair

MCW/mb



**MEDICAL BOARD OF CALIFORNIA**  
Executive Office



July 21, 2009

Edward W. Wong, M.D.  
Virtual Radiologic Prof, LLC  
11995 Singletree Lane, Suite 500  
Eden Prairie, MN 55344

RE: Physician's and Surgeon's Certificate Number: A 62280  
Case Number: 16-2009-199296

**Public Letter of Reprimand**

On May 15, 2009, the Colorado State Board of Medical Examiners issued a Letter of Admonishment based upon findings that your care and treatment of a patient fell below the generally accepted standard of practice for a radiologist in that you failed to consider a diagnosis of abscess and failed to request copies of the prior exam in order to compare the two studies. These actions are in violation of California Business and Profession Code sections 141(a), 2234 and 2305, disciplinary action taken by others and unprofessional conduct.

Pursuant to the provisions of California Business and Professions Code section 2233, you are hereby issued this Public Letter of Reprimand.

Barbara Johnston  
Executive Director

STATE MEDICAL BOARD  
OF OHIO  
2009 AUG 31 PM 2:49